(Do not write in this space)

Certificate of Election for Reduced Spouse's Benefits

1. Print Name of Wage Earner or Self-Employed Person *(Hereafter called "Worker")*	**Enter Worker's Social Security Number**
2. Print Your Full Name (*First name, middle initial, last name*)	**Enter Your Social Security Number** (*If "none" or "unknown" so indicate.*)

A spouse's insurance benefit may be payable for months between age 62 and full retirement age (FRA), even if you do not have in your care a child of the worker under age 16 or disabled entitled to a child's insurance benefit. Choosing to receive spouse's insurance benefits before FRA will result in a permanent reduction in your monthly benefits. Since such benefit will be at a permanently reduced rate and will continue at a permanently reduced rate even after FRA, the law requires that we obtain a certificate of election if you wish to receive the permanently reduced benefit. The amount of the reduction is 25/36 of 1 percent for each of the first 36 months from the start of the permanently reduced benefits to, but not including, the month you reach FRA. The reduction is 5/12 of 1 percent for each such month in excess of 36. In addition, if another beneficiary(ies) other than the wage earner (e.g., a student child beneficiary) is entitled to a monthly benefit on this Social Security number, election for a reduced spouse's benefit may cause a reduction in total monthly benefits. These reduced benefits may be paid for as many as 12 months before the month this certificate is filed. No reduced spouse's benefit may begin before the month you are 62. If you are eligible for retirement insurance benefits in the month this certificate takes effect, you will be considered to have applied for them.

3. I elect to accept permanently reduced benefits as provided in Section 202(q) of the Social Security Act, beginning with	***(Month)***	***(Year)***

4. Did you work in the railroad industry for 5 years or more? ☐ Yes ☐ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature of Person Completing this Certificate

Signature *(First Name, Middle Initial, Last Name) (Write in ink)*	Date *(Month, day, year)*
	Telephone Number (include area code)

Mailing Address *(Number and Street, Apt. No., P.O. Box, or Rural Route)*

City and State	ZIP Code

Witnesses are required ONLY if this certificate has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person completing this certificate must sign below, giving their full addresses. Also, print the applicant's name in the Signature block.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

Remarks

Privacy Act Statement
Collection and Use of Personal Information

Section 202(q)(5)(A) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent a timely and accurate decision on your eligibility for spousal benefits.

We will use the information you provide to determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

- To applicants or claimants, prospective applicants or claimants (other than the data subject), their authorized representatives or representative payees to the extent necessary to pursue Social Security claims, and to representative payees, when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting the Social Security Administration (SSA) in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and

- To third party contacts that may have information relevant to SSA's establishment or verification of information provided by representative payees or payee applicants.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422, and SORN 60-0090, entitled Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 13 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*